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ABSTRACT

This Senate testimony regarding potential improprieties in Medicaid claims for school-based health services focuses on: (1) trends in Medicaid's spending for administrative costs; (2) the distribution of Medicaid payments for administrative claims to schools and other entities; and (3) the adequacy of federal oversight in approving school districts' claims for reimbursement. The testimony asserts that over the past 4 years, school districts' claims for administrative costs associated with school-based health services have increased five-fold, and that federal oversight of claims has been weak, permitting an environment for opportunism and inappropriate claims. Sections of the testimony include: (1) "Background" (Medicaid's reimbursement of school-based administrative services, previous financing mechanisms used by states and later prohibited in law); (2) "Medicaid Claims for Administrative Expenditures Have Increased Dramatically in Some States"; (3) "In Some States, Medicaid Funds to Reimburse Schools Go to State Treasuries and Private Firms"; (4) "Insufficient HCFA Guidance, Uneven Oversight Have Led to Questionable Practices for Claiming Reimbursement" (Broad HCFA guidance leaves payment determination largely to regional discretion; HCFA oversight fails to discourage suspect billing practices); and (5) "Concluding Observations." (EV)

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Testimony

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Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

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Medicaid: Questionable Practices Boost Federal Payments for School-Based Services

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you explore potential improprieties involving Medicaid claims for school-based health services. Because Medicaid is a federal-state program, the federal government is responsible for paying a share of costs incurred by the states to serve Medicaid's 40 million low-income beneficiaries, including 19.7 million children. For eligible children who receive certain health services through their schools, states can use their Medicaid programs to help pay for these services, which include diagnostic screening and ongoing treatment. Medicaid is also authorized to reimburse schools' costs for performing administrative activities associated with Medicaid's coverage of health services, such as conducting outreach activities to enroll children in Medicaid; providing eligibility determination assistance, program information, and referrals; and coordinating and monitoring the Medicaid-covered health services.

Recently, concerns have been raised about the appropriateness of states' efforts to claim Medicaid reimbursement for school-based services. Emerging practices appear to have some disturbing similarities to other "creative" financing mechanisms that began to be used in the mid-1980s. Some states used such mechanisms to increase the federal Medicaid contributions they received without increasing their own contribution. As the nature and magnitude of such mechanisms became apparent, the Congress acted on several occasions to halt them.[1]

Recent multimillion-dollar increases in Medicaid reimbursement for school-based health services have triggered questions about the state and federal procedures in approving and overseeing these growing expenditures. Specifically, your Committee asked that we examine the rise in claims for administrative costs associated with school-based health services.[2] Accordingly, my remarks will focus on (1) trends in Medicaid's spending for administrative costs, (2) the distribution of Medicaid payments for administrative claims to schools and other entities, and (3) the adequacy of federal oversight in approving school districts' claims

[1]See Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994), Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998), and Michigan Financing Arrangements (GAO/HEHS-94-146R, May 5, 1995). See also the list of related GAO products at the end of this statement.

[2]Concerns have also been raised about (1) using a bundled rate to pay for medical services provided to Medicaid-eligible children in schools and (2) claims for school health-related transportation services for children with disabilities. On May 21, 1999, the Health Care Financing Administration sent a letter to state Medicaid directors to clarify policy on these two issues. We do not address those issues in this testimony.

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for reimbursement. My comments are based on information collected over the past 2 months, at this Committee's request, when we interviewed the 18 states identified as currently claiming administrative costs. We also visited three of these states—Illinois, Massachusetts, and Michigan—where we contacted officials at federal and state agencies, school districts, and private firms; analyzed data; and reviewed relevant documents. We also contacted officials of the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services (HHS) responsible for administering Medicaid at the federal level.

In summary, over the past 4 years, school districts' claims for administrative costs associated with school-based health services have increased fivefold—from $82 million to $469 million—in 10 states for which we could readily obtain data. Two of these states—Michigan and Illinois—accounted for most of the increases in administrative cost claims over this time period. More school districts and additional states have expressed interest in seeking Medicaid reimbursement for health-related administrative activities in schools, suggesting that claims will continue to rise.

The share of Medicaid payments for school-based administrative activities received by the schools—as opposed to other entities—varies by state. At least four states retain a portion of the federal funds obtained, whereas other states return the entire federal share directly to the school districts. School districts often contract with private firms to perform the claims development and reporting activities, and they pay these firms fees ranging from 3 to 25 percent of the total amount of the federal Medicaid reimbursement. In one state we visited, some school districts, after the state takes its share and the private firm is paid, receive only $4 of every $10 that the federal government pays to reimburse schools' Medicaid-allowable administrative costs.

Federal oversight of school districts' claims for administrative expense reimbursements has been weak. HCFA guidance has been insufficient and its reviews of districts' claims activities uneven. As a result, what is submitted by states is approved by some HCFA regional offices as an allowable administrative claim and is denied by others as questionable or unallowable. These weak controls permit an environment for opportunism in which inappropriate claims could generate excessive Medicaid payments.

Background

Under Medicaid's federal-state partnership, states operate their Medicaid programs within broad federal requirements and can elect to cover a range of optional populations and benefits. As a result, Medicaid is essentially 56 separate programs (including the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories). Each program's respective federal and state funding shares are determined through a statutory matching formula.

As part of its responsibilities for Medicaid, HCFA reviews each state's program for conformity with federal requirements. HCFA's 10 regional offices are responsible for the direct oversight of the respective state Medicaid programs within their jurisdiction, whereas HCFA's central office sets federal Medicaid policy and works with the regional offices on issues regarding state Medicaid policy and administration.

States submit claims to HCFA for Medicaid reimbursement generally under two categories: medical assistance payments and administration. Most Medicaid expenditures are for medical assistance payments; the federal share of medical assistance payments varies by state and ranges from 50 percent to 83 percent, based on each state's per capita income in relationship to the national average. Nationally, the federal share of medical assistance expenditures averaged about 57 percent in fiscal year 1998. Of Medicaid's $177 billion in total expenditures in fiscal year 1998, administrative costs were approximately $8 billion, or 4.5 percent. For administrative activities, the federal share varies by the type of costs incurred. Most administrative expenditures are matched at a fixed rate of 50 percent, making the federal government's contribution equal to that of a state. However, certain administrative activities are matched above 50 percent; for example, the development of automated systems is federally matched at a 90-percent rate. In fiscal year 1998, the federal share of payments for Medicaid's administrative costs averaged about 55 percent nationwide.

Medicaid is authorized to reimburse schools as qualified providers for covered medical assistance services provided through (1) school personnel, (2) other qualified practitioners with whom the school contracts, or (3) a combination of these approaches. School-based Medicaid-covered services that qualify for federal funds include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. Some services are provided in conjunction with the

Individuals With Disabilities Education Act (IDEA) program;[3] others are included through a state's Medicaid plan and are available through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.[4]

Medicaid's Reimbursement of School-Based Administrative Services

Medicaid is also authorized to reimburse schools for certain administrative costs, even if the school has not provided any medical assistance services. Examples of such allowable administrative activities include conducting outreach for Medicaid, helping applicants complete Medicaid enrollment forms, and arranging appointments with various providers of medical and screening services. Both IDEA and EPSDT have requirements to conduct activities that would inform and encourage individuals to participate in their benefits and services, and schools are considered a good location for identifying Medicaid-eligible children, including those with special needs.

HCFA guidance states that, to claim reimbursement for administrative costs, the schools must first identify the administrative activities associated with providing the Medicaid-covered health services and then determine their direct and indirect costs.[5] Different types of administrative activities can be totally, partially, or not eligible for Medicaid reimbursement. For some administrative activities related to Medicaid-eligible and noneligible children, the share of Medicaid eligibles among all children is applied to the activities' costs, which are claimed as Medicaid administrative costs. In addition, time studies, which track staff activities during a set period, are often used to determine the allocation between Medicaid and non-Medicaid administrative activities.

[3]IDEA, 20 U.S.C. 1400, was first enacted in 1975. It covers children with disabilities in public schools and emphasizes special education; it also covers such related services as transportation, speech pathology and audiology, psychological services, physical and occupational therapy, and counseling. Medicaid has been authorized to cover health services provided to children under IDEA through a child's Individualized Education Plan or Individualized Family Services Plan, provided the services are covered in the state's Medicaid plan, or if medically necessary, through EPSDT. Medicaid funds have been available for IDEA services since the enactment of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

[4]EPSDT is Medicaid's set of comprehensive and preventive health care services to Medicaid-eligible children under age 21. The EPSDT program provides Medicaid coverage for any medically necessary service, regardless of whether the service is covered in a state's Medicaid plan.

[5]Direct costs are activities that can be identified with a specific final cost objective, such as Medicaid administrative functions. Indirect costs are those incurred for a common or joint purpose that cannot be readily assigned to a single cost objective.

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For administrative costs to be claimed under Medicaid, they must be specified in an approved cost allocation plan.[6] According to HCFA guidance, a school district should develop its cost allocation plan in concert with the state Medicaid agency, which in turn forwards the plan to the responsible HCFA region for approval. Subsequently, the school district uses the approved plan as the basis for the cost report it forwards to the state, which then forwards claims to HCFA for Medicaid reimbursement.

Previous Financing Mechanisms Used by States and Later Prohibited in Law

The creative financing mechanisms that states began using in the mid-1980s to maximize federal Medicaid contributions, without effectively committing their own share of matching funds, took various forms. One involved using provider-specific tax revenues or provider donations paid to the state being returned to the providers with federal matching funds added. Another mechanism involved states' generating federal matching funds by increasing payment rates for a particular group of public providers, such as nursing homes or public hospitals. However, these providers, through the use of intergovernmental transfers, returned all or the majority of federal and state funds to state treasuries. Those practices that involved hospitals contributed to an explosive increase in disproportionate share hospital (DSH) payments made to hospitals that serve larger proportions of low-income and Medicaid beneficiaries—from $1 billion in 1990 to $17 billion in 1992. Federal legislation in 1991 and 1993 banned certain of these practices and placed limits on allowable reimbursable expenditures. However, the legislation did not restrict states' use of intergovernmental transfers.

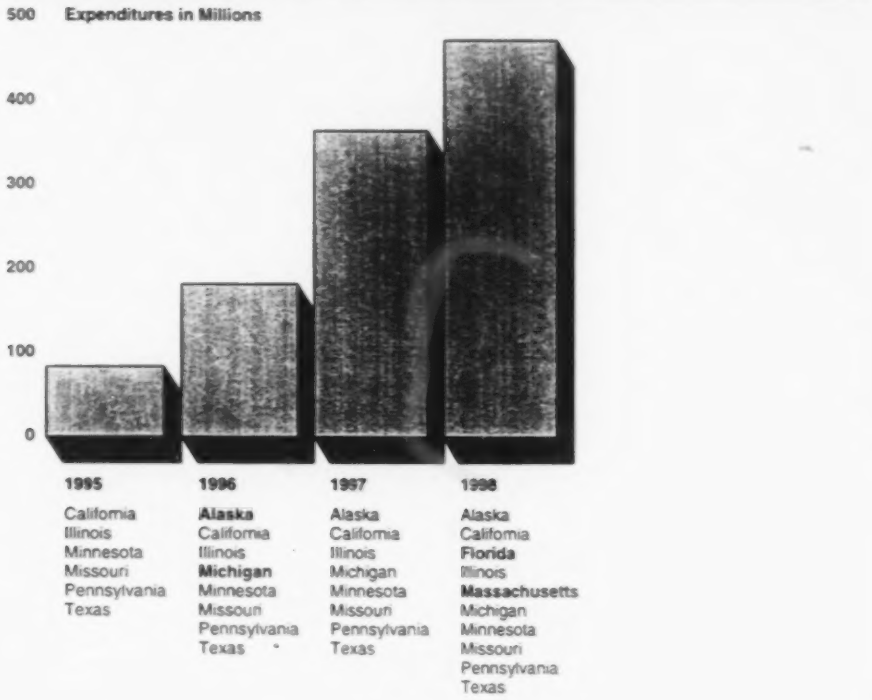
While these legislative actions significantly reduced the states' use of these financing mechanisms, states continued to find innovative ways to obtain additional federal funds. More recently, some state Medicaid programs were found to be making DSH payments to state psychiatric hospitals that were far larger on average than payments made to other types of local public and private hospitals. Overall, DSH payments to state psychiatric hospitals in six states we reviewed averaged about $29 million per hospital compared with $1.75 million for private hospitals. Such payments enabled the states to obtain federal matching funds to indirectly cover costs of services that federal law prohibits Medicaid programs from covering. In response to this practice, the Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.

[6]Cost allocation plans must abide by the cost allocation principles described in the Office of Management and Budget Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.

Medicaid Claims for Administrative Expenditures Have Increased Dramatically in Some States

A growing number of school districts are making claims for Medicaid's reimbursement of school-based administrative services. From 1995 to 1998, Medicaid expenditures claimed for administrative activities increased fivefold in the 10 states for which we could readily obtain data.[7] (See fig.1.) Two of these states—Michigan and Illinois—comprised the majority of the $387 million increase in administrative expenditures from 1995 through 1998.

Figure 1: Growth in Medicaid School-Based Administrative Claims for 10 States, FY 1995-98



Note: State names in bold are those that began claiming school-based administrative expenditures in the year listed.

Source: State-reported claims.

[7]HCFA identified 18 states that make claims for the administrative costs associated with school-based services. Because Medicaid has no separate benefit category for school-based services, not all states were readily able to provide information on their administrative expenditures for schools or school districts.

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Increases in Medicaid administrative expenditures claimed reflect a growth in both the number of schools participating and the size of claims submitted by individual school districts.[8] For example, from 1996 to 1997, Michigan's Medicaid administrative claims for schools increased almost threefold, from $79 million to $227 million, which state and school officials indicated was due primarily to an increasing number of school districts submitting claims. In contrast, Illinois school districts, which have been claiming Medicaid reimbursement since 1992, continue to identify additional activities that they believe are appropriate for Medicaid reimbursement.[9] Thus, increases in Illinois' expenditures between 1997 and 1998—from $89 million to $145 million—largely reflect increased cost claims from school districts.[10]

Barring any policy change, growth in Medicaid administrative cost claims from schools is likely to continue. Federal and state officials reported to us that other states and school districts not now making claims have expressed interest in obtaining Medicaid reimbursement for health-related administrative activities in schools. Some state officials noted that they expect to expand their claiming of costs in the near future and that they are now beginning to develop procedures and methodologies to support such an expansion. Additionally, HCFA officials commented that several states are interested in claiming Medicaid-related administrative costs but are "waiting in the wings" to ascertain whether HCFA will continue to approve certain practices for claiming administrative costs.

In Some States, Medicaid Funds to Reimburse Schools Go to State Treasuries and Private Firms

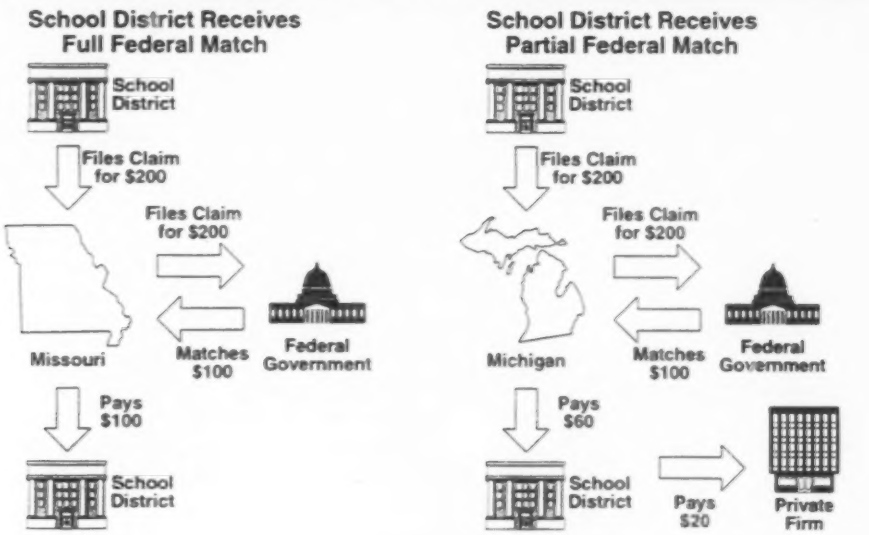
Medicaid funds to reimburse schools for administrative activities are distributed differently, depending on the state. (See fig. 2.)

[8]Administrative activities vary considerably in their content and purpose, accounting, in part, for the differences in expenditures across states. For example, some states report that the administrative activities claimed in schools primarily reflect outreach efforts on behalf of EPSDT and other Medicaid benefits. Other states with school-based medical assistance services file administrative costs related to the provision of medical services, such as coordination and monitoring of health services and interagency coordination.

[9]Chicago public schools attributed increased Medicaid revenues to additional staff training and development, legal assistance, and claims reporting assistance.

[10]Among the 10 states, Pennsylvania was the only state to have steadily lowered its administrative claims expenditures; Missouri and Texas expenditures remained relatively stable.

Figure 2: Two Approaches to School-Based Administrative Claiming



Note: Examples assume a federal share of 50 percent.

For example, Arizona, Missouri, and Rhode Island provide all federal funds to the schools, whereas at least four other states allocate a portion of the federal reimbursement to their general revenue funds. Officials in two of these states said that, because state budgets fund a portion of school activities, a school district's share of federal reimbursement for administrative claims is, in principle, partially funded by the state. Under this reasoning, states believe they are entitled to some share of the federal reimbursements claimed by school districts. The three states we visited kept some portion of the federal share, ranging from 3 percent in Massachusetts to 40 percent in Michigan. Federal dollars contributed about $1.5 million, $8 million, and $47 million to the fiscal year 1998 revenues of Massachusetts, Illinois, and Michigan, respectively. Since Michigan schools began claiming for administrative reimbursement in fiscal year 1996, the state has retained close to $106 million of the federal share.

Some school districts employ private firms to facilitate their efforts to claim Medicaid reimbursement. These firms typically receive as compensation a share of the revenues generated by the claims. By receiving a percentage rather than a fixed fee, these firms have an

incentive to maximize the amount of reimbursements claimed. Some school districts in the states we visited paid these firms fees ranging from 3 percent to 25 percent of the federal reimbursement amount, although most commonly, the fee paid was between 9 and 12 percent. One private firm is proposing to charge a flat fee that is based on the fees it has charged historically—which were originally set as a percentage of a school district's federal reimbursement received.

Marketing materials from two private firms suggest why concerns have been expressed that school districts' administrative claims may exceed reasonable or allowable costs. In these materials, the private firms note that their objectives are to maximize Medicaid revenues for schools and assert that they can maximize a school's claim potential by training school personnel to follow their methods for claiming costs. One firm emphasizes that, on average, its clients annually receive over 30 percent more per student than a competitor's.

Insufficient HCFA Guidance, Uneven Oversight Have Led to Questionable Practices for Claiming Reimbursement

Insufficient guidance, combined with uneven oversight across HCFA regions, has led to questionable billing practices by states and inconsistent federal review of states' administrative claims for school-based services. HCFA has not provided clear or consistent guidance to its regional offices regarding criteria for determining reasonable costs or appropriate methods for claiming administrative costs.

What are submitted by states and approved or denied by HCFA regions as allowable administrative costs vary widely. In the absence of specific direction from the HCFA central office, regional offices interpreted and applied the available guidance inconsistently. Practices that HCFA has allowed in one state it has not allowed in others, resulting in confusion for claimants and creating an environment in which claimants are not discouraged from testing questionable billing practices.

Broad HCFA Guidance Leaves Payment Determinations Largely to Regional Discretion

HCFA's guidance on how school districts should allocate costs to Medicaid is general to enable federal requirements to accommodate the features of 56 individual Medicaid programs. The burden of oversight necessary to ensure that administrative costs are reasonable and appropriately allocable to the Medicaid program falls to HCFA's 10 regional offices. However, guidance to the regional offices has been limited, leaving interpretation of policy and procedures up to each office. As a result, HCFA

oversight of school-based administrative cost claims has been uneven, resulting in case-by-case determinations.

Generally, HCFA directs states to follow federal requirements for administrative cost allocation found in Office of Management and Budget (OMB) Circular A-87, which establishes the principles and standards for determining "reasonable" and "allocable" costs for federal awards such as Medicaid. In addition, the Medicaid statute says that Medicaid methods of administration should be "found to be necessary by the Secretary [of Health and Human Services] for proper and efficient administration" of a state's Medicaid program.[11]

HCFA developed a technical assistance guide for states and school districts to provide more detailed guidance on Medicaid requirements associated with seeking payment for covered services (including administrative claims) in school-based settings.[12] Essentially, the guide echoes the requirements in OMB Circular A-87 and Medicaid regulations while providing a few illustrations. However, the guide does not specify criteria that would permit the systematic determination of what is reasonable and allocable to Medicaid.

The HCFA regional offices have been unsuccessful in obtaining decisive and consistent guidance from the agency's central office. For example, in 1997, a regional office requested assistance in determining what was allowable for one state's administrative claims. Multiple discussions between the two HCFA offices did not produce definitive answers. In another instance, a regional office consulted with the central office about deferring payment of a state's administrative claims until the state provided additional supporting documentation.[13] Instead, the regional office was told to pay the state but perform a postpayment review of the claims.[14] In a similar instance, another regional office deferred paying a state's questionable claims at its own initiative because it did not believe consultation was needed.

[11]Section 1902(a)(4)(A) of the Social Security Act.

[12]See HCFA, Center for Medicaid and State Operations, Medicaid and School Health: A Technical Assistance Guide (Washington, D.C.: HCFA, Aug. 1997).

[13]According to federal Medicaid regulations at 42 C.F.R. 430.40 (b), HCFA may defer a claim when it is unable to determine, on the basis of available documentation, whether a claim should be allowed.

[14]In contrast to a deferral, a postpayment review retroactively reviews practices to ensure that the claims paid were allowable.

HCFA Oversight Fails to Discourage Suspect Billing Practices

Without specific guidance, federal determinations of the appropriateness of administrative claiming practices are inconsistent, permitting the approval of claims that in some cases may be suspect. Some regions have conducted very prescriptive approaches to administrative cost claiming; others have been more "hands off." In those regions that have been "hands off," some states have tested the limits of reasonable and allowable standards, potentially maximizing Medicaid reimbursement inappropriately.

In our discussions with five regional offices, we found that their approval varied regarding states' approaches to allocating administrative costs to Medicaid. We found only one instance in which a HCFA region had been involved in the initial design of a state's cost allocation method. In other cases, state Medicaid agencies met with the regional offices for a "courtesy visit" to present their finalized cost allocation methods. In still other cases, the regional offices had no knowledge of a cost allocation plan in advance of a state's submission of administrative claims. In these cases, some regional offices deferred payments, others consulted with the central office about deferment, and still others paid the claims without further review.

We found that regional offices varied in their response to the use of various cost allocation practices that some school districts employ to enhance the amounts of Medicaid reimbursement claimed. The following are examples:

- Two regional offices found instances in which school personnel charged to Medicaid 100 percent of their activities, only a portion of which were health-related. In response, one of the regional offices identified and deferred over $33 million in inappropriate claims, while the other has proposed a deferral to HCFA's central office. In contrast, another regional office found similar instances of inappropriately billed activities but reported to us taking no action that resulted in changes on the part of the claimants.
- In two instances within one region, private firms designed activity code definitions for outreach activities that claimed 100-percent reimbursement from Medicaid,even though the activities were performed for services associated with other programs, such as WIC[15] and Food Stamps. Other

[15]WIC, or the Special Supplemental Nutrition Program for Women, Infants, and Children is a federally funded nutrition assistance program that provides lower-income pregnant and postpartum women, infants, and children up to age 5 with supplemental foods, nutrition counseling, and access to heath care services.

HCFA regions disapproved these same outreach activities when claimed by states in their jurisdiction.

- The HCFA regional offices vary in their treatment of administrative activities performed by skilled professional medical personnel, which, under certain conditions, can be matched at a 75-percent rate.[16] Where an enhanced matching rate was allowed, claims may have been overstated because, counter to Medicaid regulations, no distinction was made between skilled and unskilled activities. Two HCFA regions disallowed an enhanced matching rate altogether, with one stating that "there was no way in the world" to document that certain activities required a skilled level of performance.
- In one instance, a consortium of school districts used a sampling methodology for identifying Medicaid-eligible children that did not include sampling data from all the school districts in the consortium. To the extent that lower-income school districts were overrepresented using this method, the inflated estimate of the proportion of Medicaid-eligible children increases the amount of Medicaid reimbursement for the consortium's administrative claims.

Concluding Observations

Close to one-half of Medicaid-eligible individuals are children, making schools an important arena for Medicaid services. Even for schools that do not directly provide Medicaid services, administrative activities can help identify, refer, screen, and enroll eligible children for appropriate, covered services. Outreach and identification activities—in many and varied settings—help ensure that the nation's most vulnerable children receive routine preventive health care or ongoing primary care and treatment.

In stepping into this arena, however, some school district and state practices appear intent on maximizing their receipt of Medicaid funds through suspect financing mechanisms. Without additional guidance and consistent oversight by HCFA, many school districts with minimal knowledge of Medicaid and its billing requirements have chosen to contract with private firms. This places these firms "in the driver's seat," where they design the methods to claim administrative costs, train school personnel to apply these methods, and submit administrative claims to the state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.

[16]An enhanced matching rate of 75 percent is available for administrative activities performed by skilled professionals only if, among other things, they (1) have the appropriate credentials and (2) perform an activity that requires professional medical knowledge and skills. Hypothetically, a physical therapist would be eligible for the enhanced rate for time spent coordinating medical services but would be expected to claim at the 50-percent matching rate for time spent photocopying.

Embedded in this process are incentives for both the states and private firms to maximize Medicaid reimbursements. By being able to capture a share of the school district's federal payments, states and private firms are motivated to experiment with "creative" billing practices. At the same time, the treatment of these practices by some of HCFA's regional offices fails to adequately safeguard Medicaid dollars.

Striking a balance between the stewardship of Medicaid funds and the need for flexible approaches to ensure the coverage and treatment of eligible children is difficult. HCFA is in a position to explore policies and practices in partnership with states—and both have a fiduciary responsibility to administer Medicaid efficiently and effectively. Growing claims for school-based administrative services call for prompt attention by the federal government and the states.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Key contributors to this testimony include Carolyn L. Yocom, Susan T. Anthony, Connie Peebles Barrow, and Victoria M. Smith.

Related GAO Products

Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998).

Medicaid: Disproportionate Share Hospital Payments to Institutions for Mental Diseases (GAO/HEHS-97-181R, July 15, 1997).

State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan.23, 1996).

Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

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